Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60

Initial Comments

Fort Drum Regional Health Planning Organization (FDRHPO) responds to the August 9th, 2010 Public Notice by the Federal Communication Commission seeking comment to expand the Rural Health Care Program.

FDRHPO agrees with most of the proposed changes to the Rural Health Care program but is most interested in the following changes:

1. maintaining the same discount (85%) as the current RHCPP for MRC and NRC
2. allowing non-profits to act as administrative agents for eligible health care providers (HCP's) within a consortium
3. allowing non-profits acting as the administrative agents for eligible health care providers within a consortium to receive funding as eligible entities in order to connect data centers and administrative locations to the network they are managing.

Additionally, FDRHPO is providing comments on the following sections:

- I. INTRODUCTION, 3, 3rd Bullet: FDRHPO would like to expand on the phrase "administrative offices" to include "administrative oversight location(s) provided by non-profits in a healthcare consortium."
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, A. Program Process, 15. Initial Application Phase: How are we supposed to prove that existing available broadband infrastructure is insufficient for health IT needs? This is too open-ended. Give us measurable examples that we can use in order to increase the odds of a successful application. This process creates a significant administrative/cost burden with regards to the preparation of the project application data. In addition, this section seems to miss a basic principle of seeking broadband service. If we seek the services, there are, in almost all cases, carriers that will bid to provide the services – and include the cost of building the infrastructure to provide the service in the bid – making it impossible for the rural providers to afford because we cannot support the build-out of the infrastructure. So how can we possibly meet the criteria of "receiving no bids"? This section needs to be re-thought. Also, there seems to be no criteria for a technical review of the proposed project design. Review of the applications should be split into two sections by USAC, administrative review and technical review with the technical review having more weight. The administrative review should concentrate on the required documentation and its completeness while the technical review should concentrate on the technical aspects of the proposed design. Poorly designed/conceived projects should be returned to the applicant, with comments, for additional information.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, A. Program Process, 16. Project Selection Phase: USAC needs more technical reviewers in order to speed up the application process. Current setup in the RHCPP has many administrative reviewers and very few technical

reviewers. Administrative issues can be resolved once the technical details have been reviewed and approved.

- III. HEALTHCARE INFRASTRUCTURE PROGRAM, A. Program Process, 17. Project Commitment Phase: USAC needs to hire more technical people to review the technical plans. Less emphasis on administrative issues and more emphasis on technical concerns. Reporting should be semi-annually and not quarterly.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 1. Demonstrated Need for Infrastructure Funding, 20. Connectivity Speed: Quality of Service (QoS) should be included and it should be paid for under this proposal. Rural communities, like upstate NY, do NOT have a lot of 4M or higher Internet bandwidth solutions to pick from. Internet only solutions are not as desirable due to HIPAA concerns.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 1. Demonstrated Need for Infrastructure Funding, 21: The RHCPP put too much emphasis on the definition of "rural" and tying it to population as opposed to location. The plan needs to address communities, like Northern New York, where there are large geographic distances between locations. While some of the larger locations are not considered rural, they often are the only location capable of providing services to communities as far away as 60 miles. These distances complicate many emergency healthcare decisions like stroke and heart attack. These locations are still rural even though they have large populations when compared to the surrounding towns and villages. These larger locations need to be included in the funding in order to better serve the needs of the surrounding rural communities.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 2. Letters of Agency, 26: We think LOA's, as implemented in the RHCPP, would be acceptable in the new program.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 2. Letters of Agency, 27. Consortium Applications: Organizations (non-profits) that represent consortiums of eligible healthcare providers should be allowed to bill for administrative costs, technical support and connectivity to the network being operated and maintained by the non-profit. Rural hospitals and primary care facilities do not have the expertise, administrative overhead, technical support, or the man-hours necessary to complete all of the required documents needed to apply for the grant or maintain/operate the network once the grant is awarded. The non-profit needs the funding to hire the necessary staff to complete the initial paperwork. Additional funds are required to hire personnel to operate and maintain the network. Administration, operation and maintenance of a network are best accomplished by a group or facility that is directly connected to the network or is a part of the network. Non-profits who administer, operate and maintain telemedicine networks in support of multiple healthcare facilities or companies should be eligible for funding from the program in order to connect to the networks they are managing.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 3. Funding Requests and Budgets, 30. Cap on Amount Funded Per Project: FDRHPO Comment: Setting a cap is a good idea but a project should have a means to go back and ask for additional funding or at a minimum changes in the project as circumstances require. The RHCPP is VERY inflexible with regards to changes once the FCL has been awarded. There should always be a means to go back and ask for additional funding to cover adds/moves/changes/technologies that weren't envisioned during the initial project planning. To lock-in a project to the exact technology and scope it proposed 3 years earlier, in the information technology world, is completely inappropriate and shows a lack of technical understanding. A lack of technical understanding has been one of the key reason for the problems and failures of the RHCPP program.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial

Application for Funding, 3. Funding Requests and Budgets, 31. Cap on Number of Projects per Year: There should not be a cap on the number of projects seeking funding. If USAC had more people on staff with the technical knowledge required to determine if an applicant's bid was worthy of further consideration then more time would have been spent on helping those projects that needed extra help with the administrative process. USAC spent too much time focusing on the administrative aspects of the application (i.e.: spelling errors, address corrections, format errors) and not enough time on the technical merits of the applications.

- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 4. Eligible Costs, 37. Administrative Expenses: Administrative costs should be in addition to the overall project costs. Administrative costs should not be deducted from the overall project total but should be based on a percentage of the total cost of the project (i.e., 10%) and added to the project total.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 4. Eligible Costs, 39. Maintenance Costs: Maintenance Costs should be expanded to include on-site technical support not related to the maintenance of the infrastructure facility but instead related to the additional focus of fully utilizing the new facilities by properly administering, operating and maintain the healthcare entities current internal network facilities. Many of the plans submitted to USAC proposed linking together healthcare facilities not previously connected to one another in any way. The new network connections require the healthcare facilities to make changes to their existing internal network in order to take advantage of the new infrastructure connection (typically Wide Area Network – WAN – connections).
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 4. Eligible Costs, 40. National LambdaRail and Internet2: FDRHPO disagrees with the proposed rule to make recurring costs related to NLR/Internet2 non-eligible costs. These connections are not competed and are the most expensive connections in our area. The yearly membership fees are based on the number of locations that will have access to the connection. This is a substantial sum of money and not a cost that rural healthcare communities can easily absorb. The membership fees should be covered at 85% for up to 4 years.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 5. Ineligible Costs, 42, Personnel Costs: FDRHPO strongly disagrees with this being listed as an ineligible cost. The whole point in building a network is to reduce costs and increase access to services (in this case, healthcare service). Rural healthcare providers do not have the funds necessary to hire and properly train the technical personnel needed for the healthcare provider to take full advantage of the new network. New WAN connections require a whole new approach with regards to the healthcare providers current LAN/WAN infrastructure. By not providing funds to hire technical support staff to re-design the healthcare providers current networks you are limiting the success that can be achieved on the new WAN infrastructure. The NPRM should include funding personnel based on the number of healthcare locations being supported in the application. One technician may be able to support 3-5 rural primary care facilities while 1 or 2 technicians may be required to support larger rural or urban hospitals. FDRHPO believes the NPRM should include an exception for Personnel Costs for those applications being administered by a non-profit that acts as a legal representative for all of the healthcare facilities named in the 465 Attachment documentation. The NPRM should include support for 85% of the salary requirements (up to 3 years) for the additional technicians required to support the project. Training should also be included in the funding for the technicians so they can stay current with new technologies and Telemedicine applications.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 5. Ineligible Costs, 42, Training: The NPRM should include training for technicians. Rural healthcare facilities do not have the budgets necessary to support the levels of training required by network engineers/technicians (LAN and WAN) to keep current with new

technologies. The introduction of new network infrastructure will require healthcare facilities to re-examine their current networking infrastructure (LAN and WAN) and decide what current/future changes need to be made to take advantage of the new WAN infrastructure. This type of review often requires technical expertise that is beyond the scope of most rural healthcare facilities. The NPRM should include training expenditures up to 5% of the total project cost for a period of 3 years. The NPRM should propose that 85% of the training costs be eligible. Funding for training through the project should be awarded based on the most efficient means of training (i.e.: 1: Computer Based Training, 2: Web Based Training, 3: Live, Instructor Based Training).

- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 5. Ineligible Costs, 42, Inside wiring or networking equipment: The NPRM should include some costs for networking equipment. Routers, switches and firewalls that interface with the service provider termination equipment usually need to be upgraded to support the new high speed connections. Most rural connections have DSL or Cable connections that only run as high as 3M down/1M up. Most of the new infrastructure connections for smaller primary care facilities start at 10M Up/Down. The equipment that was used to interface with DSL/Cable ISP equipment is not usually capable of handling the higher speeds provided by the new network infrastructure equipment. Rural hospitals typically get 20M to 100M Up/Down with the new infrastructure connections but their current internal equipment is only capable of handling connections of 5M to 10M down and 1M to 3M up. The NPRM should allow funding for internal network equipment (LAN equipment) to be upgraded or replaced at those points that directly interface with the new ISP infrastructure termination equipment. The NPRM should allow for 50% of the costs for upgrades and 85% of the cost for replacement equipment (if needed).
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 5. Ineligible Costs, 42, Helpdesk equipment: FDRHPO agrees that Helpdesk equipment/software should be included as eligible costs to the application. One of the most significant reductions in costs for rural areas is in pooling Helpdesk functions, along with data center functionality, and running them from a central location in the network. This frees up hardware/software assets and reduces the number of personnel required to support existing healthcare facility LAN/WAN functions. One of the purposes of building an infrastructure that connects all of the healthcare resources in a given community, city, county, or state is the ability to merge functions currently being performed at each individual location and centralizing those functions and resources from a point on the network. Duplication of effort is reduced and overall cost of business is reduced by having these services run from a central location.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, B. Provisions Applicable to Initial Application for Funding, 5. Ineligible Costs, 43, Billing and Operational Expenses: FDRHPO disagrees. The basic concept is that meeting the billing needs of a consortium is a cost, that this is an operational cost, and that goals of the Pilot Program, the HIP and the HBSP to create regional, statewide and national health care networks requires consortium arrangements and the operational costs thereof should be considered as eligible. Non-profits who are acting as the legal entity for the healthcare facilities detailed in the Form 465 Attachment application must have additional funding in order to meet all of the administrative requirements outlined in the application. In rural communities especially, there is a lot of upfront cost in researching, coordinating and filling out all of the paperwork required as part of the application process. There is considerable travel, due to the huge geographic distances involved, and a lot of man-hours spent in gathering the required documentation from numberless and disparate healthcare organization that are represented by the legal consortium.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, C. Provisions Applicable After Initial Application, 45: As noted in the NPRM some of the applicants in the RHCPP had difficulty meeting the 15% requirement. Many rural communities are primarily serviced by non-profit

healthcare facilities. These entities do not have large amounts of disposable income available to support large infrastructure projects. I believe the contribution requirement for the HIP should remain at 15%.

- III. HEALTHCARE INFRASTRUCTURE PROGRAM, C. Provisions Applicable After Initial Application, 47, Eligible Sources: Health insurance companies and for-profit business that are not participants and are not defined as in 2 above (a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider) should be able to provide the 15% match for the infrastructure/ non-recurring portion as large employers and insurance companies bear a portion of the burden of inadequate healthcare access and healthcare inefficiencies. It is the capital or non-recurring costs that are the most difficult to secure the 15% match. The eligible health care providers are able to provide the match for the recurring costs but in rural areas just do not have any additional dollars to support the capital MRC portion. Public Authorities should also be able to provide the match funds as it is their role to assist in the development of infrastructure.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, C. Provisions Applicable After Initial Application, 4. Facilities Ownership, IRU or Capital Lease Requirements, 55: FDRHPO strongly disagrees with the prohibition of entering into short term lease agreements for managed services. While it's possible the service provider could become insolvent, the greater issue is in regards to outdated technology or equipment. From 1980 to the present day many technologies (and the associated hardware/software required to support those technologies) have become outdated or obsolete (i.e.: ATM LANs, ATM WANs, x.25 networks, full-mesh or partial-mesh private TDM networks, large scale implementation of OSI, XNS, DecNet, SNA networks). Managed Lease services centered around LTE or 4G based intranets could easily displace current networking infrastructure technologies without all of the physical connectivity costs associated with technology like SONET or DWDM (i.e.: fiber costs, right of way costs, optical to electrical conversion costs, construction costs, etc.). Locking participants into technologies that may become obsolete overnight with the introduction of newer technologies does not seem to be a good use of taxpayer dollars.
- III. HEALTHCARE INFRASTRUCTURE PROGRAM, C. Provisions Applicable After Initial Application, 4. Facilities Ownership, IRU or Capital Lease Requirements, 58. No Short-Term Leases: FDRHPO strongly disagrees. In rural communities the ISP has to build fiber runs over very long distances (upwards of 100 miles). These runs, in the example of the North Country Telemedicine Project (NCTP) network, all terminate at health care facilities. If, as this paragraph in the NPRM contends, the "ownership of the funded asset would revert back to the vendor at the conclusion of their term of the lease," what possible benefit would that provide to the ISP? The fiber terminates at an NCTP health care location. There are no other entities or companies at those locations. Who would the ISP sell service to in the future if the current occupant no longer wishes to do business with the ISP? Also, the NPRM forgets the "rural" aspect of the communities being targeted by these funds. In the case of the NCTP network the only fiber servicing most of our locations is the fiber provided by the ISP who won the RHCPP RFP bid. While there are multiple ISP's in our area, a majority of the connectivity provided by the various ISPs all share the same fiber runs. Our area does not have multiple ISPs who are willing to spend the monies necessary to build out a fiber network that will reach a significant portion of the communities in the area. FDRHPO could not afford to connect all of the entities listed in its Form 465 Attachment if it wasn't permitted to use short-term leases. FDRHPO NCTP sites pay a monthly service charge that includes the equipment and fiber costs, maintenance and support. This is based on a 4 year contract with the ISP. The provider will grant access to the fiber connections for an additional 10-15 years based on the current pricing model and current connection speeds. This allows us to take advantage of a service we couldn't possibly have funded out-right. It also allows us to look at other technology options down the road that may have better throughput at a cheaper price. It allows FDRHPO to migrate to other technologies

and solutions without being tied down to hardware/software/infrastructure that may become obsolete and difficult to maintain. Without being able to use short-term leases many rural communities would be forced to use most of their grant money to provision services to a fraction of the locations that need the service.

- III. HEALTHCARE INFRASTRUCTURE PROGRAM, C. Provisions Applicable After Initial Application, 9. Quarterly Reporting Requirements, 84: FDRHPO thinks USAC should be required to provide quarterly status reports to participants of the program detailing (1) how many projects have been approved (2) how many approved projects have been issued FCLs (3) how many projects have completed NRC invoicing for the locations listed in their Form 465 Attachment (4) how many projects have started invoicing for all of the locations listed in their Form 465 Attachment (5) how many projects have invoiced for all of the funds approved in their FCL (6) how many projects per state have been approved (7) how much of the programs money has been spent year to date.
- IV. HEALTH BROADBAND SERVICES PROGRAM, A. Eligible Services, 1. Recurring Costs, 93. Eligible Access and Transport Services: Where dedicated intranets are already in place it may be more cost effective to allow the purchase of a multi-point Internet Access. The ISP would be able to connect to the dedicated intranet with a single connection that is then virtually connected to multiple sites on the private intranet network.
- IV. HEALTH BROADBAND SERVICES PROGRAM, A. Eligible Services, 1. Recurring Costs, 97: Most ISPs have begun to offer dedicated Ethernet services at the CPE termination equipment. Minimum Ethernet speed would be 10Mbps. Most small offices have a minimum LAN speed of 10Mbps. Setting the minimum broadband connection speed to 10Mbps would allow service providers to standardize on the 10M Ethernet offering which would result in lowering the overall cost of the service. Service providers will need to offer more options if the rate is set below standard Ethernet speeds. In the long run this costs the service provider more money as they have to maintain multiple connection rates and support multiple equipment types in order to deliver these non-standard LAN rates instead of standardizing on just a few standard rates and equipment needed to support the rates. 10M, 100M and 1Gbps are standard LAN speeds and should be considered the minimum standard Broadband/WAN connection rates.
- IV. HEALTH BROADBAND SERVICES PROGRAM, A. Eligible Services, 1. No Capital or Infrastructure Costs, 100: Non-recurring costs should be funded in the same manner as the RHCPP.
- IV. HEALTH BROADBAND SERVICES PROGRAM, B. Level of Support, 106: FDRHPO believes there is significant information that could be gleaned from the RHCPP. For FDRHPO, all of the connections are to rural healthcare facilities (hospitals, primary care facilities and public health offices) and none of them were connected at speeds less than 10Mbps. Newer technologies (LTE, HSPA+) will both offer higher speeds than 4Mbps.
- IV. HEALTH BROADBAND SERVICES PROGRAM, B. Level of Support, 109: At 50% even if we can still invoice as a consortium we will likely have more than ½ of our providers drop their participation and lose their access because they simply will not be able to afford the connectivity. Their needs to be recognition that rural health care providers are often already operating in the red or have a margin so thin there is simply no wiggle room. We suggest 70% with additions up to 85% for HCPs with specific defined characteristics (e.g. in HPSA, is Meaningful User, provides >30% care to Medicaid or non-paying/sliding fee clients etc.).
- IV. HEALTH BROADBAND SERVICES PROGRAM, B. Level of Support, 113. Opting into the Health Broadband Services Program: FDRHPO strongly supports permitting Pilot Program participants to transition to the HBSP w/o any restrictions.
- V. ELIGIBLE HEALTH CARE PROVIDERS, D. Skilled Nursing Facilities, 125: FDRHPO believe the best means of determining eligibility as a skilled nursing facility should be dependent upon at least 51% of revenues generated are for skilled nursing services.

- VII. OFFSET RULE, 137: FDRHPO supports removal of the offset rule.
- IX. DATA GATHERING AND PERFORMANCE MEASURES, B. "Meaningful Use" Criteria, 143: FDRHPO is not opposed to this but believes that those who are meaningful users should get a higher discount and that this must be carefully planned in terms of phase-in dates – perhaps not beginning as a requirement until after 2014 at a minimum.

Respectfully Submitted,

Robert P. Hunt
Regional Telemedicine Project Manager

Fort Drum Regional Health Planning Organization
120 Washington Street
Suite 302
Watertown, NY 13601